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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 6275 CERTIFICATE OF DEATH 06240										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Summit Avenue					d. STREET ADDRESS 303 Summit Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First IRENE Middle MAY Last ALBERT					4. DATE OF DEATH Month May Day 18 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1881		9. AGE (In years lost birthday) yrs. 79		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance Agency		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Powles Albert					14. MOTHER'S MAIDEN NAME Alice Dunn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Name George D. Albert Address Hagerstown, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 hr. Indefinite										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 11, 1960 to May 18, 1960 , that (I) (we) last saw the deceased alive on May 11, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE <i>B. B. Kneisley</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/19/60			
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.					22d. ADDRESS 148 West Washington St., Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Suter - Rouzer Funeral Home</i>					ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>	

CERTIFICATE OF DEATH

(M)

Washington

1000 10th St

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

1
6276
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06241

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 110 W. High St.	
c. LENGTH OF STAY IN lb 4 Days		d. STREET ADDRESS Hancock Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Bain		4. DATE OF DEATH Month 5 Day 2 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3. 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 5 Days 27	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber	
11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W Bain		14. MOTHER'S MAIDEN NAME Catherine Bain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1908		16. SOCIAL SECURITY NO. 220-18-1303	
17. INFORMANT Catherine C Bain		Address Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 456X Azotemia and Hyperglycemia DUE TO (b) Glomerular arteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema; subendocardial hemorrhage, rt. ventricle; Hypertrophy, rt. ventricle; Uremic colitis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 27, 1960, to May 2, 1960, that (I) (we) last saw the deceased alive on May 2, 1960, and that death occurred at 9:25 a.m. M, from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.5.60	
23c. NAME OF CEMETERY Demascus Christian		23d. LOCATION (City, town, or county) (State) Fulton County Penn.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone		25a. REC'D BY REGISTRAR DATE MAY 9 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Stone	

1934

CERTIFICATE OF DEATH

1934



Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Jan 15, 1934		New York City		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Medical History		Previous Illnesses		Present Illness		Treatment	
[Text]		[Text]		[Text]		[Text]	
Burial Place		Burial Date		Burial Time		Burial Officer	
[Text]		[Text]		[Text]		[Text]	

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VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6277 CERTIFICATE OF DEATH

06242

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b Life time					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
e. STREET ADDRESS 460 Park Place									
3. NAME OF DECEASED (Type or print) LOUISE (no) BECKETT				4. DATE OF DEATH MAY 6 1960					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 8 1893			
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland USA.			
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME Nathan Simms				14. MOTHER'S MAIDEN NAME Emma Barten					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 210-22-8618		17. INFORMANT Mrs Edith Beek 437 Park Place Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446 X IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) NEPHROSCLEROSIS DUE TO (c) UNKNOWN								INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CEREBRAL THROMBOSIS, GENERALIZED ARTERIOSCLEROSIS								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from MAY 5 1960 , to MAY 6 1960 , that (I) (we) last saw the deceased alive on MAY 6 1960 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.									
22a. SIGNATURE George Bercu				22b. DATE SIGNED 5/6/60					
22c. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU				22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson ADDRESS Hagerstown Md.				25a. REC'D BY REGISTRAR MAY 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

10-24-54

CERTIFICATE OF DEATH

8271



Decedent's Name: [Illegible]
Date of Birth: [Illegible]
Place of Birth: [Illegible]
Sex: [Illegible]
Race: [Illegible]
Marital Status: [Illegible]
Occupation: [Illegible]
Cause of Death: [Illegible]
Manner of Death: [Illegible]
Signature: [Illegible]
Date: [Illegible]



10-24-54

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VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6341
CERTIFICATE OF DEATH

06243

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b 3 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Men Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VICTOR Middle BOVEY Last BENTZ		4. DATE OF DEATH Month May Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 31 1869
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 03 Days 03 Hours 03 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Punkstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Bentz		14. MOTHER'S MAIDEN NAME Sarah Jane Bovey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John C. Bentz McDonogh		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 10 1960 to May 19 1960 , that (I) (we) last saw the deceased alive on May 18 1960 , and that death occurred at 3P M, from the causes and on the date stated above.			
22a. SIGNATURE G W Hevan		22b. DATE SIGNED 5/20/60	
22c. PHYSICIAN'S NAME (Type) G W Hevan		22d. ADDRESS Boonsboro Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR DATE MAY 23 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

11

WASHINGTON

BOONSHAW

2 Yrs

Washington

Marion-K. H. van Hone

1988

VICTOR

BOVEY

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John D. Bovey

John D. Bovey

Hone

John D. Bovey

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6278

CERTIFICATE OF DEATH

06244

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle RAPHAEL Last BOWARD		4. DATE OF DEATH Month May Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 3, 1903
9. AGE (In years last birthday) 57 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silk Weaver	10b. KIND OF BUSINESS OR INDUSTRY Textile
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Franklin Boward		14. MOTHER'S MAIDEN NAME Emma Virginia Clowes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-4263	
17. INFORMANT Mr. Raphael E. Boward		Address Hagerstown, Md. 805 W. Washington St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic valvular heart disease with aortitis 421.4 DUE TO and congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Indefinite			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 11 , 19 57 , to May 8 , 19 60 that I last saw the deceased alive on May 7 , 19 60 , and that death occurred at 2:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. B. Kneisley, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 148 West Washington St. 5/9/60	
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 11, 1960	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR MAY 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

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6279

CERTIFICATE OF DEATH

06245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 Dual Highway				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Paul Middle Elwood Last Brant				4. DATE OF DEATH Month May Day 3 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Berlin, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lincoln Brant				14. MOTHER'S MAIDEN NAME Rebecca Brant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 190-05-6238		INFORMANT Marion Brant, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Coronary arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 min 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 19 59 , to May 3 , 19 60 , that I last saw the deceased alive on May 3 , 19 60 , and that death occurred at 6 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul Harrison M.D. 318 N. Potomac St. 5-4-60 Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-6-60		22c. NAME OF CEMETERY OR CREMATORY Somerset Memorial Park		22d. LOCATION (City, town, or county) (State) Somerset, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE MAY 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1234

Washington

MD.

5 months

Washington

1100 East Highway

1100 East Highway

Front

Wood

Wood

August 20, 1900

White

White

Bethesda, Md.

Washington

Washington

Robertson

Lincoln

Nation Front, Bethesda, Md.

1900-05-038

no

Complete material with certificate

1-0-00

Official

Robert F. Minnich & Son, Washington, D.C.

6343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Wash.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Wash.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maugansville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Maugansville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maugansville, md</i>		d. STREET ADDRESS <i>1 Maugansville, md</i>	
3. NAME OF DECEASED (Type or print) <i>NANCY</i> First Middle Last <i>- Buterbaugh.</i>		4. DATE OF DEATH <i>May 23</i> Month Day Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/17/1881</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>near Mercersburg, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David L. Martin</i>		14. MOTHER'S MAIDEN NAME <i>Sara Eker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Raymond Buterbaugh - Maugansville, md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>200.1 Lympho sarcoma</i> DUE TO (b) <i>Leukemia</i> DUE TO (c) <i>7 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12-1-58</i> to <i>5-23-60</i> , that I last saw the deceased alive on <i>5-22-60</i> , 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. E. Winnich</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>3/4/60</i>	
PHYSICIAN'S NAME (Type) <i>A. E. Winnich</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B.</i>	22b. DATE THEREOF <i>5/25/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Broadfording Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Wash. Co., md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. E. Winnich - Greencastle, Pa.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAY 31 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06247

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b most of life 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Y. M. C. A.		d. STREET ADDRESS 212 N. Potomac Street	
3. NAME OF DECEASED (Type or print) First PAMELA Middle LEE Last CAREY		4. DATE OF DEATH Month May Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1953
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School girl		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ft. Monmouth, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Carey		14. MOTHER'S MAIDEN NAME Barbara Jean Mc Sherry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Barbara Jean Dunn		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 929.4 DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Interval between onset and death: Instant		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in swimming pool at Y.M.C.A.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:40 p.m. 5-21-1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Y.M.C.A.		20f. (City or town) (County) (State) Hagerstown, Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature]		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-23-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/1960	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		24a. REC'D BY REGISTRAR DATE MAY 25 '60	
24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jay Bland Carr		4. DATE OF DEATH Month May Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1918
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Electricial	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Carr		14. MOTHER'S MAIDEN NAME Verna V. Maugans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary K. Carr		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Infarct, left Hemisphere DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Thrombosis Internal Carotid Artery DUE TO (c) 3 days.		INTERVAL BETWEEN ONSET AND DEATH 3 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1960 to May 16, 1960 that I last saw the deceased alive on May 16, 1960 at 11:45 A.M. and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. A. Bell</i>		ADDRESS (Street, city or town, state) 119 N. Potomac St. Hagerstown Md.	
PHYSICIAN'S NAME (Type) R. A. Bell		DATE SIGNED 5-18-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-60	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE MAY 20 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haines</i>	

1
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Washington

Washington

Washington

Washington

Washington County Hospital

Washington County Hospital

Day

Day

Day

White

January 22, 1918

White

January 22, 1918

January 22, 1918

James Cox

James V. Lawrence

James V. Lawrence

11:25

11:25

11:25

11:25

Recd from University

11:25

11:25

Recd from University

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
6282
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06249

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>6 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LEITERSBURG - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R. 5</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>M.</u> Last <u>CLOPPER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY-17-1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BEAVER CREEK WASH. CO. MD. USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>SAMUEL LINEBAUGH</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH REYNOLDS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>GEORGE D. CLOPPER HAGERSTOWN MD. R. 5</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesentery Thrombosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>5-28-60</u> to <u>5-30-60</u> , that (I) (we) last saw the deceased alive on <u>5-30-1960</u> , and that death occurred at <u>9:45 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. E. W. Ditto, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				22d. ADDRESS <u>15 W Washington Hagerstown</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE-2-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WELTY CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>NR. SMITHSBURG WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Best</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

CERTIFICATE OF DEATH

383

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

CHIEF OF BUREAU

TO HOWARD AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6349 CERTIFICATE OF DEATH 06250

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville				c. LENGTH OF STAY IN 1b 1 Yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mennonite Old Folks Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES MAIN CLOPPER				4. DATE OF DEATH May 29 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20 1865	
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Leitersburg Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Simon Clopper				14. MOTHER'S MAIDEN NAME Nancy Leight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Verdeen Clopper				Address 430 Summit Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 430.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Chronic Arterio-sclerotic heart disease DUE TO (c) Generalized arterio sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 yrs 12 yrs 12 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 15 1959 to May 29 1960 , that (I) (we) last saw the deceased alive on May 24 1960 , and that death occurred at 6 PM from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Wishard M.D.				22b. DATE SIGNED May-31-60			
22c. PHYSICIAN'S NAME (Type) WALTER H. WISHARD, M.D.				22d. ADDRESS 152 W. Main Waynesboro Penna			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/1/60			
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR JUN 6 '60			
ADDRESS Hagerstown Md				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



WALTER H. WILSON, JR.

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WALTER H. WILSON, JR.

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WALTER H. WILSON, JR.

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WALTER H. WILSON, JR.

6283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06251

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS Route 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First John Middle W Last Commer		4. DATE OF DEATH Month 5 Day 12 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1959		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 9 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kenneth Ray Commer				14. MOTHER'S MAIDEN NAME Nancy Kurlene Webb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address John W. Commer Hagerstown, Md. R 4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis Emphysema DUE TO 019.2 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Miliary Tuberculosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 days 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 9 May 1960 to 12 May 1960 , that (I) (we) last saw the deceased alive on 12 May 1960 , and that death occurred at 12:00 M, from the causes and on the date stated above.							
22a. SIGNATURE J. D. Wilson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/14/60	
22c. PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.				22d. ADDRESS 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5-16-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 17 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss			

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10521

CERTIFICATE OF DEATH

1933



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Form with multiple lines for text entry, including fields for name, age, sex, race, and date of death. The text is mostly illegible due to fading and bleed-through.

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Form with multiple lines for text entry, including fields for cause of death, place of death, and signature. The text is mostly illegible due to fading and bleed-through.

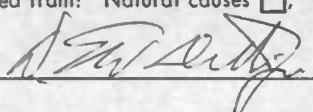
MADE IN U.S.A.

10521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6350 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06252

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leitersburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>State Highway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Vermont</u> b. COUNTY <u>Lamoille</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutland</u> 82X-3 d. STREET ADDRESS <u>93 Crescent St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond Earle Davis</u>				4. DATE OF DEATH Month Day Year <u>May 30 1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14, 1915</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing materia</u>				11. BIRTHPLACE (State or foreign country) <u>Morrisville Vermont</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Burton Davis</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>009-01-3769</u>				17. INFORMANT Address <u>Funkhouser Co. Hagerstown Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left Chest Crushed</u> DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Collision at Junction of State R # 418 and 64</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>10:10</u> P. M. <u>5-30-1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R# 418 - 64</u>				20f. (City or town) <u>Binggold</u> (County) <u>Wash.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>						22b. DATE THEREOF <u>May 31, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morrisville, Vermont</u>				22d. LOCATION (City, town, or county) <u>Morrisville, Vermont</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>						24a. REC'D BY REGISTRAR <u>DATE JUN 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6351 CERTIFICATE OF DEATH 06253

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lydia Middle Lurena Last Dick		4. DATE OF DEATH Month 5 Day 18 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7.11.1873
9. AGE (In years lost birthday) yrs. 86		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Otho Shives		14. MOTHER'S MAIDEN NAME Dorothy Trumpower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-9136	
17. INFORMANT Y		Address William R Mounker Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 mo 30 yr. 30 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 27, 1959 to 4-28, 1960 , that (I) (we) last saw the deceased alive on April 28, 1960 , and that death occurred at 11:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frank B Thomas III M.D.		22b. DATE SIGNED 5/20/60	
22c. PHYSICIAN'S NAME (Type) Frank B. Thomas III, M.D.		22d. ADDRESS Hancock, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.21.60	
23c. NAME OF CEMETERY OR CREMATOR St Thomas Episcopal		23d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Elmore		25a. REC'D BY REGISTRAR DATE MAY 24 '60	
ADDRESS Hancock Md		25b. REGISTRAR'S SIGNATURE Charles A. Harris	

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U.S. GOVERNMENT PRINTING OFFICE: 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6284

CERTIFICATE OF DEATH

06254
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (Rural) Sharpsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1 Rural Sharpsburg	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Sheridan Last Drenner		4. DATE OF DEATH Month May Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21 1874
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months 0 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Near Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Silas Henry Drenner		14. MOTHER'S MAIDEN NAME Mary Domer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records- Fahrney Memorial Home		Address Boonsboro Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized cardio-vascular disease (c) Haemorrhage from duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 10 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2 , 19 60 , to May 13 , 19 60 , that I last saw the deceased alive on May 13 , 19 60 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Livan		ADDRESS (Street, city or town, state) Boonsboro	
PHYSICIAN'S NAME (Type) G. W. Livan		DATE SIGNED 5/14/60 Ind.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Legg Williamsport, Md		24a. REC'D BY REGISTRAR MAY 17 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6285

CERTIFICATE OF DEATH

Reg. Dist. No.

06255

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>L.</u> Middle <u>Durham</u> Last		4. DATE OF DEATH <u>May</u> Month <u>4</u> Day <u>1960</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mineville, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. E. Stimpson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Locke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>E. Warner Harsh</u> Address <u>Greencastle Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-2-60</u> , 19 <u>60</u> , to <u>5-4-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-3-60</u> , 19 <u>60</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. E. W. D. L. T. O. J.</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>5/6/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. D. L. T. O. J.</u>		M.D. <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cr.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Munnich</u> ADDRESS <u>Greencastle Pa.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAY 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6352 CERTIFICATE OF DEATH

06256

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock Md.		c. LENGTH OF STAY IN 1b 55 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 2 Hancock Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS rural 2 Hancock Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Eddy				4. DATE OF DEATH Month 5 Day 12 Year 19 60			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.8.1883		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Orchard		11. BIRTHPLACE (State or foreign country) Franklin County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H Eddy				14. MOTHER'S MAIDEN NAME Mary Corblet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-9065		17. INFORMANT Address Mrs Lillian M Eddy Rural 2 Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Carcinoma Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1959 to May 1960 that (I) (we) last saw the deceased alive on May 12 60 and that death occurred at 8 M, from the cause and on the date stated above.							
22a. SIGNATURE L.M. SHAFER				22b. DATE SIGNED 6/16/60			
22c. PHYSICIAN'S NAME (Type) Hancock, Md.				22d. ADDRESS L.M. SHAFER MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5.16.60		23c. NAME OF CEMETERY OR CREMATORY Park Head Cemetery		23d. LOCATION (City, town, or county) (State) Park Head Washington Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. L. L. Hancock Md				25a. REC'D BY REGISTRAR DATE MAY 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kress	



*Received from
The American
Legation*

1891

*Mr. C. W. Smith
July 8
Washington*

W. H. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 514 N. Mulberry St.				d. STREET ADDRESS 514 N. Mulberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Knute Middle Fredrik Last Engstrom				4. DATE OF DEATH Month May Day 21 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1907		
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Fredrik Engstrom				14. MOTHER'S MAIDEN NAME Matilda Strid				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 362-09-6233		17. INFORMANT Address Mrs Virginia Engstrom Hagerstown Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage following Laceration Of DUE TO 900.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Carotid Artery And Cavernous Sinus DUE TO Fracture Left Frontal Bone With Extension in the (c) Base. </p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Pratically Instant</p> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps while going to apartment on 2nd. floor.						
20c. TIME OF INJURY Month, Day, Year Hour 4:30 P. M. 5-21-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Wash. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-26-60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR MAY 26 60		
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1970-1989 20

4-10-1941

1000

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6287

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa. 75x.3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Nursing Home</u>		d. STREET ADDRESS <u>417 S. Carlisle ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth B. Etter</u>		4. DATE OF DEATH <u>May 18 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Quincy Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elam Hess</u>		14. MOTHER'S MAIDEN NAME <u>Emma Summers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Clifford Etter - Greencastle Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infiltrating glioma left temporal lobe</u> DUE TO <u>193.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>60</u> , to <u>May 18</u> , 19 <u>60</u> , that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R Hess</u> M.D.		ADDRESS (Street, city or town, state) <u>Greencastle Pa</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>David R Hess M.D.</u>			
22a. BURIAL, CREMATION, REBURY (Specify)	22b. DATE THEREOF <u>5/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brown's Mill</u>	22d. LOCATION (City, town, or county) (State) <u>Kaufman Station, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Winnick - Greencastle Pa.</u>		24a. REC'D BY REGISTRAR ADDRESS DATE <u>MAY 20 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

6288

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06259

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>BOONSBORO MD. R12.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE EDGAR FAULDERS</u>				4. DATE OF DEATH Month Day Year <u>MAY - 17. 19 60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 10. 1908</u>	9. AGE (In years lost birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours <u>6 7</u>	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN E. FAULDERS</u>				14. MOTHER'S MAIDEN NAME <u>LEAH STINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>HUBERT L. FAULDERS</u>		Address <u>BOONSBORO MD. R.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>420.0</u> DUE TO <u>Congestive heart failure due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months</u> <u>indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1957</u> to <u>May 16 1960</u> , that (I) (we) last saw the deceased alive on <u>May 16 1960</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Keadle</u>				22b. DATE SIGNED <u>5-18-60</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u>	
22d. ADDRESS <u>318 N. Potomac St., Hagerstown, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 19 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Boonsboro MD</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>	

10830

CERTIFICATE OF DEATH

10830



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
6289
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06260

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 11 East Lincoln Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle VIRGINIA Last GAUSE				4. DATE OF DEATH Month May Day 18 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1906	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Funkstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Albert G. Smith South				14. MOTHER'S MAIDEN NAME Florence Stouffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Robert T. Gause Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Breast DUE TO (b) Metastases to Lungs DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2-1-1960 to 5-18-1960 , that (I) (we) last saw the deceased alive on 5-16-60 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. E. W. J. T. T. J.				22b. DATE SIGNED 2-18-60			
22c. PHYSICIAN'S NAME (Type) Dr. E. W. J. T. T. J.				22d. ADDRESS 215 W. Washington Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

10550

CERTIFICATE OF DEATH

6282

Washington

Washington

Washington County Hospital

DAVID

YERGEN

WASH

June 10, 1905

White

WILKINSON, W. J.

Wash

Joseph S. Smith

Joseph S. Smith

Joseph S. Smith

no

no

6353

CERTIFICATE OF DEATH

06261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOWNSVILLE c. LENGTH OF STAY IN 1b 2 MO. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOBBURN NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO d. STREET ADDRESS 10X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWIN FELTY GEESEY		4. DATE OF DEATH Month Day Year MAY 24 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/10/1869
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BASKET MAKER - SELF EMP.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME EDWIN D. GEESEY		14. MOTHER'S MAIDEN NAME MARY ANN FELTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NAME AL. GEESEY, HAGERSTOWN MD	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac myocardial infarction 420.1 DUE TO (b) Day Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 5/23/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) WOODSBORO MD	
21. I certify that I attended the deceased from 5/23/60 , 19____, to 5/24/60 , 19____, that I last saw the deceased alive on 5/24/60 , 19____, and that death occurred at WOODSBORO , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WOODSBORO MD DATE SIGNED 5/24/60			
ACTUAL SIGNATURE Ralph Young		M.D. William Sport	
PHYSICIAN'S NAME (Type) RALPH YOUNG		WILLIAMSPORT MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27/60	
22c. NAME OF CEMETERY OR CREMATORY MT HOPE		22d. LOCATION (City, town, or county) (State) WOODSBORO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Cramer - Woodstock - Md Byron - New Windsor - Md		24a. REC'D BY REGISTRAR DATE MAY 27 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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The undersigned

Attest
J. J. [Signature]
J. J. [Signature]

06262

2081203xv2

CERTIFICATE OF DEATH

6280

Registration

Part I

Part II

John Doe

John Doe

100 Main Street

Washington County, Oregon

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6291

See: Birth Cert. et

CERTIFICATE OF DEATH

07383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Middle Last Griffith		4. DATE OF DEATH Month Day Year May 30 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1960
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min. 3 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lloyd Sylvester Griffith		14. MOTHER'S MAIDEN NAME Mildred Eva Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30 , 19 60 , to May 30 , 19 60 , that I last saw the deceased alive on May 30 , 19 60 , and that death occurred at 6:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis G. Graff		M.D. 119 E. Antietam	
PHYSICIAN'S NAME (Type) Louis G. Graff, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/3/60	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hospital		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis G. Graff		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

2081-315XV0

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6292

06263

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore, 29			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 1/2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cora Middle Elizabeth Last Gruber				4. DATE OF DEATH Month May Day 3 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1874	
9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Hagerstown, Wash. Cty. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Garver				14. MOTHER'S MAIDEN NAME Martha Doup			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Rev. Lavelly V. Gruber, 808 Walnut Ave Address Baltimore, 29th Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X General arteriosclerosis with DUE TO (b) Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) 2-3 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Empyema gall bladder							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1958 to May 3, 1960 , that (I) (we) lost the deceased alive on May 3, 1960 , and that death occurred at 3 PM , from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Ditto III				22b. DATE 5/4/60			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.				22d. ADDRESS 217 West Washington Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery, Hagerstown, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				25a. REC'D BY REGISTRAR MAY 9 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6293 **CERTIFICATE OF DEATH**

06264

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 60 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 735 Washington Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Susan Middle Ann Last Harsh				4. DATE OF DEATH Month May Day 24 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 2 Days 26		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Cearfoss Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME William Harsh				14. MOTHER'S MAIDEN NAME Mary Sprinkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. George Harsh 308 Vale St. Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crownary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 36 hrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-1-1979 to 5-24-1960 , that (I) (we) last saw the deceased alive on 5-23-1960 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE A. E. W. J. T. O. G.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. E. W. J. T. O. G.				22d. ADDRESS 215 N. Washington Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26-60		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City, town, or county) (State) Near Clearspring Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md.				25a. REC'D BY REGISTRAR MAY 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

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Maryland

Hagerstown

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White

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U.S.A.

Leontine M.

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Monmouth

Mary Monmouth

William Harsh

308 Vale St.
Hagerstown Md.

None

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6354

CERTIFICATE OF DEATH

06265

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 5 c. LENGTH OF STAY IN 1b 10 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fiddlersburg		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 5 d. STREET ADDRESS Fiddlersburg e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL ELLSWORTH HATFIELD		4. DATE OF DEATH Month Day Year May 1 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kiln Burner No Amer Cement Corp.		10b. KIND OF BUSINESS OR INDUSTRY Union Bridge Carroll Co	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Hatfield		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Herman Hatfield		Address 143 No Cleveland Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 5 yrs. DUE TO (c) 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-31 19 60 , to 1960 , that (I) (we) last saw the deceased alive on 4-21 19 60 , and that death occurred at 5:30 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess		22d. ADDRESS Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR DATE MAY 6 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Charles E. Hanes	

CERTIFICATE OF DEATH

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1954

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

6294

CERTIFICATE OF DEATH

Reg. Dist. No.

06266

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>10 West Side Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last <u>Hicks</u>		4. DATE OF DEATH Month Day Year <u>May 13 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1960</u>	
9. AGE (In years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Robert Joseph Hicks</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Helena Redmond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature delivery</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature rupture of membranes</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amnionitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>60</u> , to <u>May 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>60</u> , and that death occurred at <u>4:16 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harold H. Gist</u> M.D.							
PHYSICIAN'S NAME (Type) <u>H. H. Gist, M.D.</u>				<u>111 N. Potomac St., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Gist</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAY 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

Mars 6/60 2081313XV0

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: John J. Smith]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>		<p>4. DATE OF BIRTH [Handwritten: 10-15-1880]</p>		<p>5. PLACE OF BIRTH [Handwritten: Boston, Mass.]</p>	
<p>6. OCCUPATION [Handwritten: Clerk]</p>		<p>7. MARITAL STATUS [Handwritten: Married]</p>		<p>8. DATE OF DEATH [Handwritten: 11-10-1925]</p>		<p>9. PLACE OF DEATH [Handwritten: Home]</p>		<p>10. CAUSE OF DEATH [Handwritten: Heart Disease]</p>	
<p>11. SIGNATURE OF DECEASED [Signature]</p>		<p>12. SIGNATURE OF WITNESS [Signature]</p>		<p>13. SIGNATURE OF DECEASED [Signature]</p>		<p>14. SIGNATURE OF WITNESS [Signature]</p>		<p>15. SIGNATURE OF DECEASED [Signature]</p>	
<p>16. SIGNATURE OF WITNESS [Signature]</p>		<p>17. SIGNATURE OF DECEASED [Signature]</p>		<p>18. SIGNATURE OF WITNESS [Signature]</p>		<p>19. SIGNATURE OF DECEASED [Signature]</p>		<p>20. SIGNATURE OF WITNESS [Signature]</p>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6295

CERTIFICATE OF DEATH

06267

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>APPLETOWN - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA M HINES</u>				4. DATE OF DEATH Month Day Year <u>MAY-14 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL-17-1887</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WILLIAM PHILHOWER</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>JOHN H. HINES JR. BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>Acute Thromboflebitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous cell carcinoma of cervix</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>60</u> , to <u>May 14</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>May 14</u> 19 <u>60</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Secondari</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>				22d. ADDRESS <u>21 N. Main St., Boonsboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 17 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>				ADDRESS <u>BOONSBORO MD</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Carlton S. Harris</u>			

10564

CERTIFICATE OF DEATH

10564



MAINE COUNTY



MAINE COUNTY



MAINE COUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6296 CERTIFICATE OF DEATH 06268

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 George Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Noah Middle Arthur Last Hines		4. DATE OF DEATH Month May Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY B.L. Mills Service Station	
11. BIRTHPLACE (State or foreign country) Woodstock Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrison Hines		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 0662 214-09-	
17. INFORMANT Mrs. Emma Hines		Address 613 George St. Hag. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerotic Heart Disease 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5-6 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/25 1955 to 5/18 1960 , that (I) (we) last saw the deceased alive on 5/17 1960 , and that death occurred on 5/18 AM , from the causes and on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 5/18/60	
22c. PHYSICIAN'S NAME (Type) George Jennings		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-20-60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A.K. Coffman		24. ADDRESS Hagerstown Maryland	
25a. REC'D BY REGISTRAR MAY 23 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



6293

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
BALTIMORE, MARYLAND

Registration

Age 12 years

2 years

Registration

112 George Street

112 George Street

John

Arthur Hines

John Hines

John Hines, Nov. 29, 1931

John Hines

John Hines, Nov. 29, 1931

John Hines

John Hines

21-42

John Hines, Nov. 29, 1931

John Hines, Nov. 29, 1931



CHIEF

CLERK

CLERK

CLERK

CLERK

CLERK

CLERK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6355

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook c. LENGTH OF STAY IN 1b 24 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook d. STREET ADDRESS Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle ROSANNA Last HOFFMAN				4. DATE OF DEATH Month May Day 14 , Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78		IF UNDER 24 HRS. Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Harpers Ferry, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Tyler Kilham				14. MOTHER'S MAIDEN NAME Laura Virginia Dixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rev. Leonard Hoffman RFD # 1, Knoxville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) General Arteriosclerosis (c) 420.1 DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1						INTERVAL BETWEEN ONSET AND DEATH 4 hours 5 years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				DATE SIGNED 5-14-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/60		22c. NAME OF CEMETERY OR CREMATORY Harper Cemetery		22d. LOCATION (City, town, or county) (State) Harpers Ferry, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Donald Zickler				ADDRESS Harpers Ferry, W.Va.		24a. REC'D BY REGISTRAR DATE MAY 17 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

100

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6297
CERTIFICATE OF DEATH

06270

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Walter Last Hoffman		4. DATE OF DEATH Month 5 Day 2 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter- paper hanger		10b. KIND OF BUSINESS OR INDUSTRY own business	
11. BIRTHPLACE (State or foreign country) Warren Co. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Mary C. Hansbrough		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Benign Prostatic Hypertrophy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 wk
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 19 60 to May 2 19 60 that (4) (we) last saw the deceased alive on 5/2 19 60 , and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Paul Harrison		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 5-4-60	
23c. NAME OF CEMETERY OR CREMATORY Charles Evans Crematory		23d. LOCATION (City, town, or county) (State) Reading Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		25a. REC'D BY REGISTRAR DATE MAY 4 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

5

1

1

CHEE TAIN

200-1101

1901

CERTIFICATE OF DEATH

MADE AND THE DEPARTMENT OF HEALTH

1901

Registration

2 years

Registration

San. Co. No. 101

San. Co. No. 101

James

Walter

Walter

Wife: White

Wife: White

13

Religion - Roman Catholic

Religion - Roman Catholic

Religion - Roman Catholic

Unknown

Unknown

no

no

no

no

no

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
6356
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06271

1. PLACE OF DEATH a. COUNTY <i>Wash.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Wash.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown - Rural</i>		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Hagerstown RD 6</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JOHAS</i> Middle <i>E.</i> Last <i>HORST</i>		4. DATE OF DEATH Month <i>May</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/9/1886</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Marylandville, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John V. Horst</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Eshleman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. -	
17. INFORMANT <i>Mrs. Nancy Horst - Hagerstown, Md.</i>		Address <i>RD 6</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> 4-50.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Compensation by slow time</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i> <i>5 years</i> <i>10 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-20-60</i> to <i>5-28-60</i> , that (I) (we) last saw the deceased alive on <i>5-20-60</i> , 1960, and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>A. E. Wittig</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>A. E. Wittig Jr.</i>		22d. ADDRESS <i>Hagerstown Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/1/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Reiff Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Pearfoss, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. E. Minnich - Greencastle, Pa.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 3 '60</i>	
ADDRESS <i>A. E. Minnich - Greencastle, Pa.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kenna</i>	

00830

CERTIFICATE OF DEATH

00830



CHILLIKAL

MADE IN INDIA

6298

CERTIFICATE OF DEATH

Reg. Dist. No.

06272

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEW HOURS X CLEAR SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT CLARENCE MEADE HOUCK		4. DATE OF DEATH Month Day Year MAY 12 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 25, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE	
11. BIRTHPLACE (State or foreign country) CLEAR SPRING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID F. HOUCK		14. MOTHER'S MAIDEN NAME ELIZEBETH SPOPE HOUCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-16-2725	
17. INFORMANT Address MISS MILDRED HOUCK CLEAR SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGIE DUE TO HYPERTENSIVE ARTERIOSCLEROTIC DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB 3, 1960 to MAY 12, 1960 that I lost saw the deceased alive on MAY 12, 1960 and that death occurred at 8.10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.			
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		CLEAR SPRING, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 14, 1960	22c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL CEM.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i> ADDRESS CLEAR SPRING, MD.		24a. M.D. BY REGISTRAR MAY 16 1960	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 19

6299

CERTIFICATE OF DEATH

06273
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) CARLOCK CONV. MEM. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE EDGAR HUFFER		4. DATE OF DEATH MAY 22 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COLLECTOR		10b. KIND OF BUSINESS OR INDUSTRY ELEC. POWER CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONAS Q. HUFFER		14. MOTHER'S MAIDEN NAME MARY E. NEIKIRK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 214- 10-4620	
17. INFORMANT MRS. MARY HUFFER		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 28 , 19 58 , to May 22 , 19 60 , that I last saw the deceased alive on May 22 , 19 60 , and that death occurred at 11:58 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE SIDNEY ROVE NOSTEIN M.D.		ADDRESS (Street, city or town, state) HAGERSTOWN MD. DATE SIGNED 5-23-60	
PHYSICIAN'S NAME (Type) SIDNEY ROVE NOSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/24/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		24a. REC'D BY REGISTRAR MAY 26 60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1920

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NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOOBS BOND RT 2		c. LENGTH OF STAY IN 1b 4 YRS 3 MO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.		03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHNEY REEDY MEN. HOME				d. STREET ADDRESS 3700 Campfield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL		First		Middle HUNTER		Last	
4. DATE OF DEATH MAY		Month		Day 25		Year 1960	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1896	
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY American Can Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Hunter				14. MOTHER'S MAIDEN NAME Margaret Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. F. Earle Dance - 3700 Campfield Rd. #7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis (b) Viral pneumonia (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1960, to May 25, 1960, that I last saw the deceased alive on May 24, 1960, and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED G. W. LeVan M.D. Baltimore 5/25/60 G. W. LeVan Fried							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 5/27/60		22c. NAME OF CEMETERY OR CREMATORY Lorraine Maus.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Pickener & Sons - Balto. 17 mid				24a. REC'D BY REGISTRAR DATE MAY 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

6523

Date of Birth 1900		Date of Death 1900	
Sex Male		Race White	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.	
Cause of Death Heart Disease		Manner of Death Natural	
Date of Death 1900		Time of Death 10:00 A.M.	
Place of Death Home		Name of Physician Dr. J. H. Smith	
Name of Informant J. H. Smith		Address of Informant 1234 Main St.	
Signature of Informant J. H. Smith		Signature of Physician Dr. J. H. Smith	
Date of Report 1900		Name of Registrar J. H. Smith	
Address of Registrar 1234 Main St.		Signature of Registrar J. H. Smith	

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6357

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06275

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EZRA KELLER ISEMINGER</u>				4. DATE OF DEATH Month Day Year <u>MAY-21-1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-27-1874</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>11 24</u>	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>		11. BIRTHPLACE (State or foreign country) <u>FUNKSTOWN WASH. Co. MD. USA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MICHAEL ISEMINGER</u>				14. MOTHER'S MAIDEN NAME <u>ROSE KERNS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>218-30-9558</u>		17. INFORMANT Address <u>RAY H. ISEMINGER FUNKSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5, 1960</u> to <u>May 21, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 20, 1960</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R.A. Bell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 23, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>				22d. ADDRESS <u>Hagerstown, Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 24 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FUNKSTOWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>FUNKSTOWN WASH. Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bost</u>				ADDRESS <u>BOONSBORO MD</u>		25a. REC'D BY REGISTRAR <u>MAY 26 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>R. H. H. H.</u>	



1

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE: [illegible]



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06276

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 S. Conococheague Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oscar Middle C. Last Johnson				4. DATE OF DEATH Month May Day 15 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13 1899	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Corp. of Williamsport		11. BIRTHPLACE (State or foreign country) West Va.	
12a. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John H. Johnson		14. MOTHER'S MAIDEN NAME Rosetta Giffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216 07 1197		17. INFORMANT Mrs. Fay Johnson Williamsport, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA Lung & Metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 14R				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5/15/60 to 5/15/60 , that (I) (we) last saw the deceased alive on 5/15/60 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Beck F. Young				22b. DATE SIGNED 5/16/60		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18-60		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf				24a. ADDRESS Williamsport, Md.		24b. REC'D BY REGISTRAR DATE MAY 18 '60	
24c. REGISTRAR'S SIGNATURE Arthur L. Kraus							

CENTRAL OF DEATH

Washington

20 yrs.

Washington

In Concochessie Street

In Concochessie Street

Occup

John H.

W

12

12

Male White

Nov. 13 1893

1

Williamson

Wash D.C.

London

John H. Johnson

Robert G. G. G.

In Concochessie Street

Nov 13 1893

Nov 13 1893

Gravestone of John H. Johnson

Gravestone of John H. Johnson

Gravestone of John H. Johnson

Gravestone of John H. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6300

CERTIFICATE OF DEATH

302

06277

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle LUCILLE Last KARN		4. DATE OF DEATH May 8 1960 Month May Day 8 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14 1934
9. AGE (In years lost birthday) 25 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Netz		14. MOTHER'S MAIDEN NAME Katherine Durbin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs Katherine Netz 243 E. Franklin St		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 674X DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. Phlebotomy - Right Post. Iliac Ven. Right posterior tibial vein (b) Immediate (c) 1 day		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cesarean Section 2 days previously.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 21 1959 to May 8th 1960 , that (I) (we) last saw the deceased alive on May 8th 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 5/9/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St., Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/60	
23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City, town, or county) (State) Boonsboro Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR MAY 13 1960 DATE	
25b. REGISTRAR'S SIGNATURE Andrew K. Coffman			

6200

CENTRAL OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6301 CERTIFICATE OF DEATH

06278

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 45 W. Fenton Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ada Middle Pearl Last Kelley				4. DATE OF DEATH Month May Day 8 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3 1893		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 0 Days 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Near Hopewell Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonas Hoffman				14. MOTHER'S MAIDEN NAME Barbara Ellen Lowery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Albert Kelley Address 45 Fenton Ave. Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Ac myocardial infarction due to Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. Frank heart & lungs (b) THROMBOSIS OF CORONARY ARTERIES (c) FRANK HEART & LUNGS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/6/60 to 5/8/60 , that (I) (we) last saw the deceased alive on 5/8/60 , and that death occurred at 5:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. F. J. Young				22b. DATE SIGNED 5/9/60		22c. PHYSICIAN'S NAME (Type) Dr. F. J. Young	
22d. ADDRESS Williamsport Md.				22e. ADDRESS Williamsport Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10-60		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Kelley				25a. REC'D BY REGISTRAR MAY 10 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Washington	Harvard	Washington	Harvard
Hogartson	Williamson	Hogartson	Williamson
Washington County Hospital	45 W. Carson Ave.	Washington County Hospital	45 W. Carson Ave.
Adm	Relief	Adm	Relief
Female	May 3 1933	Female	May 3 1933
Hospital	West Hospital	Hospital	West Hospital
James Hoffman	Barbara Allen Lowry	James Hoffman	Barbara Allen Lowry
No	45 Horton Ave.	No	45 Horton Ave.
Name	Tr. Albert Kelley	Name	Tr. Albert Kelley

Washington County Hospital
45 W. Carson Ave.
Adm
Female
May 3 1933
West Hospital
James Hoffman
Barbara Allen Lowry
45 Horton Ave.
Tr. Albert Kelley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
6302
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
66279
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>10 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u> d. STREET ADDRESS <u>1 MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>TRAVIS D. KNODE</u> First Middle Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1960</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886 OCT-8-1960</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>24</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED POST MASTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>				11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. CO. MD. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JACOB KNODE</u>				14. MOTHER'S MAIDEN NAME <u>MOLLIE YOUNG</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-18-1260</u>		17. INFORMANT <u>MRS. MARY KNODE KEEDYSVILLE MD</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> 1960 to <u>May 2</u> 1960 , that (I) (we) last saw the deceased alive on <u>5/1</u> 1960 and that death occurred at <u>4 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Heurter</u>				22b. DATE <u>5-2-1960</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph Secundari, M. D.</u>		22d. ADDRESS <u>21 N. Main St., Boonsboro, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 5, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. CO. MD.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				24a. ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

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CERTIFICATE OF DEATH

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PHILIP J. ALLEN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06280

6303

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Harriett Last Knodle		4. DATE OF DEATH Month May Day 16 , Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1871
9. AGE (In years last birthday) yrs. 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY bank	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin F. Knodle		14. MOTHER'S MAIDEN NAME Harriett Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-18-2787A	
17. INFORMANT Mrs. Janet Snyder, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia + Malnutrition 450-0 DUE TO generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Uremia (c) Uremia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia INTERVAL BETWEEN ONSET AND DEATH Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-15, 1960 , to 5-16, 1960 , that I last saw the deceased alive on 5-16, 1960 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md. DATE SIGNED 5:17:60			
ACTUAL SIGNATURE John H. Hornbaker		M.D. John H. Hornbaker, M.D.	
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-19-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE MAY 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

CERTIFICATE OF DEATH

1933

Washington

MA.

Age

Life

Married

110 Broadway

Washington County Hospital

Amelia

Paralyzed

104

November 9, 1933

Female

Washington, Md.

Dark

Black

Harriet Street

Benjamin F. Smith

215-1-2782 Mrs. Janet Taylor, Washington, D.C.

110 Broadway

110 Broadway

110 Broadway

110 Broadway

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110 Broadway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6304 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07395

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland				c. LENGTH OF STAY IN 1b 7 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 146 N. Jonathan Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle (no) Last Knex				4. DATE OF DEATH Month May Day 31 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9 1923	
9. AGE (In years last birthday) 37 yrs.		12. UNDER 1 YEAR Months 3 Days 12		13. UNDER 24 HRS. Hours 19 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.			
11. BIRTHPLACE (State or foreign country) USA.				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME William Knox				14. MOTHER'S MAIDEN NAME Clara Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War 11				16. SOCIAL SECURITY NO. 217-18-6119			
17. INFORMANT Mrs Mary Whitmore				Address 309 N Jonathan St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 DUE TO Acute Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy DUE TO (c) 12 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 hours INTERVAL BETWEEN ONSET AND DEATH 12 hours							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John R. Watson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John R. Watson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/7/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR JUN 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6305
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

06281

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 S. Mulberry St.				d. STREET ADDRESS 118 S. Mulberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ALMER Last KREGALO				4. DATE OF DEATH Month May Day 25 Year 1960					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1894			
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Telephone Company		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland			
13. FATHER'S NAME William Kregelo				14. MOTHER'S MAIDEN NAME Martha Schwinger					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. I 212-10-0584		17. INFORMANT Address Mrs. Margaret Kregelo Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edemascarcinoma of Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulosis of Colon								INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Hagerstown				20g. (County) Maryland					
21. I certify that (I) (this hospital) attended the deceased from 7-11 1959 to 5-25 1960 that (I) (the) last saw the deceased alive on 5-25 1960 and that death occurred at 7 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Dalton M. Welty				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.				22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home B. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 31 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kious									

INDEX

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5. *Proctos* (1992) *Journal of the American Statistical Association*, 87, 100-109.

11-5

7. 10. 1991

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

6345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06283

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>7 mos. 1 week - 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>128 N. ARTIZAN ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Jane Frances D. Leiter</u>				4. DATE OF DEATH <u>May 19 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 5, 1874</u>	
9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Victor Cushman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kreigh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary Fry Williamsport</u> Address <u>128 N. Artizan Street Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> 794A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Cachexia</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic hip infection</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>May</u> , Day <u>19</u> , Year <u>1960</u> Hour <u></u> o. m. <u></u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1 1958</u> to <u>May 19 1960</u> , that (I) (we) last saw the deceased alive on <u>May 15 1960</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Max F. Byrkit</u>				22b. DATE SIGNED <u>5-19-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Max F. Byrkit</u>				22d. ADDRESS <u>28 W Potomac Wmpt Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 21, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roschill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u>				25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	
				DATE <u>MAY 23 '60</u>			

1938

CERTIFICATE OF DEATH

1938



[Faint, mostly illegible text from a death certificate form, including fields for name, date, and location.]

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CENTRAL FILE OF DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6343

CERTIFICATE OF DEATH

06284

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>BOONSBORO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 MCKELPIN DRIVE</u>				d. STREET ADDRESS <u>10 MCKELPIN DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LLOYD FENTON LOHMAN</u>		First Middle Last		4. DATE OF DEATH <u>MAY 13 1960</u>		Month Day Year	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY-16-1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>27</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>DC TRANSIT CO.</u>		11. BIRTHPLACE (State or foreign country) <u>SHARPSBURG WASH. CO. MD. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AUGUST LOHMAN</u>				14. MOTHER'S MAIDEN NAME <u>IDA CREAGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-10-6836</u>		17. INFORMANT <u>MRS. MARY LOHMAN</u> Address <u>10 MCKELPIN DRIVE BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS -</u> DUE TO (b) <u>CARDIO-VASCULAR DISEASE -</u> DUE TO (c) <u>5 minutes</u> 6 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 13 1960</u> to <u>May 13 1960</u> , that (I) (we) last saw the deceased alive on <u>May 13 1960</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Lohan</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Lohan</u>				22d. ADDRESS <u>Boonsboro - Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY-16-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MIDDLETOWN FRED. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bast</u>				ADDRESS <u>BOONSBORO MD</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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DR. LEVAY

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CERTIFICATE OF DEATH

2343

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DEPARTMENT OF HEALTH
STATE OF NEW YORK
BUREAU OF VITAL STATISTICS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 17½ hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural 10X-2	
3. NAME OF DECEASED (Type or print) First Daniel Middle Theodore Last Long		4. DATE OF DEATH Month May Day 28 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1942
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Russell Donald Long		14. MOTHER'S MAIDEN NAME Hallie May Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-38-2030	
17. INFORMANT Mrs. Hallie M. Long		Address Thurmont, Md. RD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE SUBDURAL HEMATOMA, LEFT DUE TO 823X Conditions, if any, which gave rise to immediate cause (b) CEREBRAL CONGESTION AND EDEMA DUE TO 17½ HRS. (c) PULMONARY CONGESTION & EDEMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SPEEDING-SOUTH OF THURMONT RT. # 550 STOCK CULVERT		INTERVAL BETWEEN ONSET AND DEATH 17½ HRS.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SPEEDING-SOUTH OF THURMONT RT. # 550 STOCK CULVERT	
20c. TIME OF INJURY Month, Day, Year 11:30 PM 5-27 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ROUTE 550		20f. (City or town) (County) (State) THURMONT FRED. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE DR. E.W. DITTO, JR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) DR. E.W. DITTO, JR.		DATE SIGNED 5/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-1-60	
22c. NAME OF CEMETERY OR CREMATORY Utica Cemetery		22d. LOCATION (City, town, or county) (State) Utica Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, 19

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6358

CERTIFICATE OF DEATH

Reg. Dist. No. 06286

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Fulton</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Big Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Big Cove Tannery</u>	
3. NAME OF DECEASED (Type or print) First <u>Finley</u> Middle <u>M. (No name)</u> Last <u>Lynch</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1884</u> 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Big Cove Tannery</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dallas Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Martha Peck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>F.S. Lynch, Rt. 1 Big Springs, Md.</u>	
17. INFORMANT <u>F.S. Lynch, Rt. 1 Big Springs, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>MAY 24, 1960</u> to <u>MAY 24, 1960</u> , that I last saw the deceased alive on <u>May 24, 1960</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.		PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u> Clear Spring, Maryland May 24, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 27, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) <u>Pt. Connellysburg, Pa.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.M. Lininger</u> ADDRESS <u>Merensburg, Pa.</u>		24a. REC'D BY REGISTRAR <u>JUN 6 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6308
CERTIFICATE OF DEATH

06287

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 537 Frederick St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Lee LYNN		4. DATE OF DEATH Month 5 Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 12, 1875
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George B. Lynn		14. MOTHER'S MAIDEN NAME Catherine Bly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. G. Miller Lynn, Same as # 2	
17. INFORMANT G. Miller Lynn, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Broncho Pneumonia, Bilateral DUE TO Thrombosis of right middle cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Three weeks DUE TO (c) one week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lung abscess Thrombosis of pulmonary artery			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 8, 1960 to May 31, 1960 that (I) (we) last saw the deceased alive on May 31, 1960 , and that death occurred at 9:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED June 1, 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Young E. Chun		22d. ADDRESS 1500 Penna Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF 6-3-1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		23d. LOCATION (City, town, or county) (State) Winchester, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE A.K. Coffman		25a. REC'D BY REGISTRAR 6 '60	
25b. REGISTRAR'S SIGNATURE Carlton S. Knaus			

(M)

(1)

RECEIVED
JUN 10 1964

0300

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

10000

Robert Lee LYNCH

The undersigned of right mind, competent, and of legal age, do hereby certify that the above named person died on the 10th day of June, 1964, at the residence of the decedent, 1500 Kinn Ave., Buffalo, New York.

Witness my hand and seal this 10th day of June, 1964.
J. Edgar Hoover
Director

1500 Kinn Ave. Buffalo, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6309 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 years 6 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>26 S. Mulberry Street</u>				1d. STREET ADDRESS <u>26 S. Mulberry Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ADELE</u> Last <u>MAC MICHAEL</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 17, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Music Publishing Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Lancaster, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>? Wall</u>				14. MOTHER'S MAIDEN NAME <u>Mary Marrin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-30-9536</u>		17. INFORMANT Address <u>Mrs. William T. Hassett, Jr Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Atherosclerosis</u> (c) <u>Myocardial Infarct</u> (d) <u>Cardiac Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>				24a. REC'D BY REGISTRAR ADDRESS <u>Hagerstown, Md.</u> DATE <u>MAY 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

POST-MORTEM EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF SURGEON		18. SIGNATURE OF NURSE	
19. SIGNATURE OF PATHOLOGIST		20. SIGNATURE OF ANATOMIST		21. SIGNATURE OF HISTOLOGIST	
22. SIGNATURE OF BACTERIOLOGIST		23. SIGNATURE OF CHEMIST		24. SIGNATURE OF PHYSICIAN	
25. SIGNATURE OF DENTIST		26. SIGNATURE OF VETERINARIAN		27. SIGNATURE OF PHARMACEUTICIAN	
28. SIGNATURE OF OPTICIAN		29. SIGNATURE OF ENGINEER		30. SIGNATURE OF ARCHITECT	
31. SIGNATURE OF MECHANIC		32. SIGNATURE OF ELECTRICIAN		33. SIGNATURE OF PLUMBER	
34. SIGNATURE OF PAINTER		35. SIGNATURE OF CARPENTER		36. SIGNATURE OF JOINER	
37. SIGNATURE OF MILLWRIGHT		38. SIGNATURE OF BLACKSMITH		39. SIGNATURE OF COOPER	
40. SIGNATURE OF WHEELWRIGHT		41. SIGNATURE OF SADDLERY		42. SIGNATURE OF SHOELEATHER	
43. SIGNATURE OF HATMAKER		44. SIGNATURE OF JEWELLER		45. SIGNATURE OF OPTICIAN	
46. SIGNATURE OF WATCHMAKER		47. SIGNATURE OF SILVERSMITH		48. SIGNATURE OF GOLDSMITH	
49. SIGNATURE OF ENAMELER		50. SIGNATURE OF STONECUTTER		51. SIGNATURE OF GLASSBLAS	
52. SIGNATURE OF POTTER		53. SIGNATURE OF CERAMICIST		54. SIGNATURE OF TEXTILE WORKER	
55. SIGNATURE OF LEATHERWORKER		56. SIGNATURE OF FURRIER		57. SIGNATURE OF HATTER	
58. SIGNATURE OF MILLINER		59. SIGNATURE OF DRESSMAKER		60. SIGNATURE OF TAILOR	
61. SIGNATURE OF HAIRDRESSER		62. SIGNATURE OF BEAUTICIAN		63. SIGNATURE OF COSMETOLOGIST	
64. SIGNATURE OF NAIL TECHNICIAN		65. SIGNATURE OF EYEBROW PLUCKER		66. SIGNATURE OF LASH LIFT	
67. SIGNATURE OF SKIN CARE SPECIALIST		68. SIGNATURE OF HAIR REMOVAL SPECIALIST		69. SIGNATURE OF MAKEUP ARTIST	
70. SIGNATURE OF STYLING SPECIALIST		71. SIGNATURE OF HAIR COLOR SPECIALIST		72. SIGNATURE OF HAIR CUT SPECIALIST	
73. SIGNATURE OF HAIR TREATMENT SPECIALIST		74. SIGNATURE OF HAIR RESTORATION SPECIALIST		75. SIGNATURE OF HAIR TRANSPLANT SPECIALIST	
76. SIGNATURE OF HAIR LOSS SPECIALIST		77. SIGNATURE OF HAIR GROWTH SPECIALIST		78. SIGNATURE OF HAIR CARE SPECIALIST	
79. SIGNATURE OF HAIR STYLING SPECIALIST		80. SIGNATURE OF HAIR DESIGN SPECIALIST		81. SIGNATURE OF HAIR ART SPECIALIST	
82. SIGNATURE OF HAIR CONSULTANT		83. SIGNATURE OF HAIR EDUCATOR		84. SIGNATURE OF HAIR RESEARCHER	
85. SIGNATURE OF HAIR INNOVATOR		86. SIGNATURE OF HAIR PIONEER		87. SIGNATURE OF HAIR VISIONARY	
88. SIGNATURE OF HAIR FUTURE		89. SIGNATURE OF HAIR DREAM		90. SIGNATURE OF HAIR HOPE	
91. SIGNATURE OF HAIR BELIEF		92. SIGNATURE OF HAIR FAITH		93. SIGNATURE OF HAIR TRUST	
94. SIGNATURE OF HAIR LOVE		95. SIGNATURE OF HAIR PASSION		96. SIGNATURE OF HAIR DEVOTION	
97. SIGNATURE OF HAIR COMMITMENT		98. SIGNATURE OF HAIR DEDICATION		99. SIGNATURE OF HAIR SACRIFICE	
100. SIGNATURE OF HAIR GIVING		101. SIGNATURE OF HAIR RECEIVING		102. SIGNATURE OF HAIR EXCHANGING	
103. SIGNATURE OF HAIR TRADING		104. SIGNATURE OF HAIR SELLING		105. SIGNATURE OF HAIR BUYING	
106. SIGNATURE OF HAIR DONATING		107. SIGNATURE OF HAIR BORROWING		108. SIGNATURE OF HAIR LENDING	
109. SIGNATURE OF HAIR LOANING		110. SIGNATURE OF HAIR RENTING		111. SIGNATURE OF HAIR LEASING	
112. SIGNATURE OF HAIR LICENSING		113. SIGNATURE OF HAIR FRANCHISING		114. SIGNATURE OF HAIR PARTNERING	
115. SIGNATURE OF HAIR JOINT VENTURING		116. SIGNATURE OF HAIR INVESTING		117. SIGNATURE OF HAIR FINANCING	
118. SIGNATURE OF HAIR CREDIT		119. SIGNATURE OF HAIR DEBIT		120. SIGNATURE OF HAIR BALANCE	
121. SIGNATURE OF HAIR OVERDRAFT		122. SIGNATURE OF HAIR DEFICIT		123. SIGNATURE OF HAIR SURPLUS	
124. SIGNATURE OF HAIR EXCESS		125. SIGNATURE OF HAIR DEFICIENCY		126. SIGNATURE OF HAIR ABUNDANCE	
127. SIGNATURE OF HAIR SCARCITY		128. SIGNATURE OF HAIR RICHNESS		129. SIGNATURE OF HAIR POVERTY	
130. SIGNATURE OF HAIR WEALTH		131. SIGNATURE OF HAIR DEATH		132. SIGNATURE OF HAIR LIFE	
133. SIGNATURE OF HAIR DESTRUCTION		134. SIGNATURE OF HAIR CREATION		135. SIGNATURE OF HAIR REDEMPTION	
136. SIGNATURE OF HAIR RESURRECTION		137. SIGNATURE OF HAIR REBIRTH		138. SIGNATURE OF HAIR RENEWAL	
139. SIGNATURE OF HAIR RESTORATION		140. SIGNATURE OF HAIR REPAIR		141. SIGNATURE OF HAIR REBUILDING	
142. SIGNATURE OF HAIR RECONSTRUCTION		143. SIGNATURE OF HAIR REFORMATION		144. SIGNATURE OF HAIR REGENERATION	
145. SIGNATURE OF HAIR REPRODUCTION		146. SIGNATURE OF HAIR REPRODUCTION		147. SIGNATURE OF HAIR REPRODUCTION	
148. SIGNATURE OF HAIR REPRODUCTION		149. SIGNATURE OF HAIR REPRODUCTION		150. SIGNATURE OF HAIR REPRODUCTION	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6310

CERTIFICATE OF DEATH

06289

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 1 Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRA Middle CLIFTON Last MARKER				4. DATE OF DEATH Month May Day 23 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Frederick County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel Marker				14. MOTHER'S MAIDEN NAME Cynthia Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Herbert Johnson Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) carcinoma of the rectum DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 mos. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 25, 1960 to May 23, 1960 , that (I) (we) last saw the deceased alive on May 23, 1960 , and that death occurred at 5:18 PM , from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 23, 1960	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS				22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/26/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown Wm. G. Stolt. Md.				ADDRESS		25a. REC'D BY REGISTRAR MAY 25 60 DATE	
				25b. REGISTRAR'S SIGNATURE Wm. G. Stolt			

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6311

CERTIFICATE OF DEATH

Reg. Dist. No.

06290

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlocks Nursing Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna May Marr		4. DATE OF DEATH Month May Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1884
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months 5 Days 9 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upper Fitter		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew H. Marr		14. MOTHER'S MAIDEN NAME Emma Rose Wallich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-5838	
17. INFORMANT Miss Irene Marr		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease with myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1955 to 10 May 1960 , that I last saw the deceased alive on 10 May 1960 , and that death occurred at 10:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F F Lusby		DATE SIGNED 10 May 60	
PHYSICIAN'S NAME (Type) F F Lusby		ADDRESS (Street, city or town, state) 230 N Poloma St Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR Hagerstown Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAY 12 '60	

6311

CERTIFICATE OF DEATH

Washington

Washington

Washington

1918

Washington

Georgetown Hospital

1111 11th Ave.

Age

Sex

Mar

Prof

10

50

Female White

Nov. 28, 1918

Upper Liver

Acute Gastric

Washington

Andrew H. Hart

George Ross Wilson

210-00-0000

Washington

George Ross Wilson

George Ross Wilson

Serial 7-11-00

Howe Hill Cemetery

Washington

George Ross Wilson

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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6312

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06291

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 6 mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Md. Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Chase d. STREET ADDRESS N. Union Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James H. Martin		4. DATE OF DEATH 5 23 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/1877
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR 83 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Elevator Operator Altoona, Pa.	
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James H. Martin		14. MOTHER'S MAIDEN NAME Honora Teller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records of Md. State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis 420.1 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease. Cancer of right ear and scalp. Diabetes mellitus.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 80 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 25 19 59 to May 23 19 60 , that (I) (we) last saw the deceased alive on May 23 19 60 , and that death occurred at 2:20 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED May 23, 1960	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1960	
23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR MAY 27 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

(14)

Washburn

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may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DR. E.W. DITTO JR

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6359
CERTIFICATE OF DEATH

06292

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK RURAL</u>				c. LENGTH OF STAY IN 1b <u>6 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN MD. R.I.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA AMELIA MARTZ</u>				4. DATE OF DEATH Month Day Year <u>MAY-19- 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY-21-1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		9. AGE (In years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>BEAVER CREEK WASH. CO. MD. USA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>JACOB DETROW</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA EASTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT Address <u>MRS. LEROY SMITH HAGERSTOWN MD R.I.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronch. Pneumonia Relapsed</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO <u>Senility</u> (c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>5 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>4-2-60</u> to <u>5-19-60</u> , that (I) (we) last saw the deceased alive on <u>5-16-60</u> , and that death occurred <u>9:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>E. W. Ditto</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>E. W. DITTO</u>				22d. ADDRESS <u>210 W Washington Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 22, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Best</u> ADDRESS <u>BOONSBORO MD</u>				25a. REC'D BY REGISTRAR <u>MAY 23 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>							

CERTIFICATE OF DEATH

6323

00303

1

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06293

6313

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 28 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 523 Reynolds Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 523 Reynolds Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RACHEL Middle B Last McCormack		4. DATE OF DEATH Month May Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1869
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Saltville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Buskill		14. MOTHER'S MAIDEN NAME Martha Countess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. E. D. Miller		Address 523 Reynolds Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arterio Sclerosis (Cerebral) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs. DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) General Arterio Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 4, 1960 to May 6, 1960 , that I last saw the deceased alive on May 6, 1960 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Beachley		DATE SIGNED May 6, 1960	
PHYSICIAN'S NAME (Type) J. H. Beachley		M.D. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Old Glade Springs Cemetery		22d. LOCATION (City, town, or county) (State) Glade Springs Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS Wm. G. Hook	
24a. REC'D BY REGISTRAR MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

1913

<p>1. Name of deceased 2. Sex 3. Age 4. Date of birth 5. Place of birth 6. Date of death 7. Place of death 8. Cause of death 9. Signature of physician 10. Signature of registrar 11. Date of registration 12. Place of registration</p>	<p>13. Name of informant 14. Sex 15. Age 16. Date of birth 17. Place of birth 18. Date of death 19. Place of death 20. Cause of death 21. Signature of physician 22. Signature of registrar 23. Date of registration 24. Place of registration</p>
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1. Name of deceased
 2. Sex
 3. Age
 4. Date of birth
 5. Place of birth
 6. Date of death
 7. Place of death
 8. Cause of death
 9. Signature of physician
 10. Signature of registrar
 11. Date of registration
 12. Place of registration

13. Name of informant
 14. Sex
 15. Age
 16. Date of birth
 17. Place of birth
 18. Date of death
 19. Place of death
 20. Cause of death
 21. Signature of physician
 22. Signature of registrar
 23. Date of registration
 24. Place of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6314 CERTIFICATE OF DEATH

06294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Shack	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 271 S. Prospect St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Miller		4. DATE OF DEATH Month Day Year May 9th 1960					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1960	9. AGE (In years last birthday) yrs. 12	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Benson Miller		14. MOTHER'S MAIDEN NAME Rose Marie Barr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEDICAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 1960 , 19____, to May 9, 1960 , 19____, that I last saw the deceased alive on May 9 , 19 60 , and that death occurred at 6:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE F. D. Dove Jr.		M.D.					
PHYSICIAN'S NAME (Type) Dr. F. D. Dove, Jr.		214 North Potomac St., Hagerstown, Md.					
22a. BURIAL CREMATION, OTHER (Specify) 22b. DATE THEREOF 5/12/60		22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hospital Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. D. Dove Jr.		ADDRESS 214 N. Potomac St., HagMd		24a. REC'D BY REGISTRAR DATE MAY 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Mass 6/60 2081283XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06295

Reg. Dist. No.

6315

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 23 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1700 Howell Road				d. STREET ADDRESS 1700 Howell Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Herbert Clinton Moats				4. DATE OF DEATH May 22 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1882		
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Cold Storage		11. BIRTHPLACE (State or foreign country) Tilghmontont Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Henry Moats				14. MOTHER'S MAIDEN NAME Susan Davis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-10-3415		17. INFORMANT Address Mrs. Florence Dorsey Williamsport Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							INTERVAL BETWEEN ONSET AND DEATH 5 Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE [Signature] M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-60		22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		22d. LOCATION (City, town, or county) (State) Near Tilghmontont Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott. F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR MAY 26 '60		24b. REGISTRAR'S SIGNATURE [Signature]		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6312

NAME OF DECEASED William Henry		SEX Male	
DATE OF BIRTH Dec. 11, 1892		AGE 32 years	
PLACE OF BIRTH Haverhill, Mass.		RESIDENCE 1700 Howell Road, Haverhill, Mass.	
OCCUPATION Salesman		CAUSE OF DEATH Coronary thrombosis	
MEDICAL HISTORY None		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		DATE Dec. 11, 1924	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6316 **CERTIFICATE OF DEATH**

06296

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 W. Hilcrest Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle AARON Last MOATS				4. DATE OF DEATH Month May Day 16 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1921	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY Penal Farm		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Carl Moats				14. MOTHER'S MAIDEN NAME Lola Showe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W. II 214-09-2974		17. INFORMANT Mrs. Jacqueline Moats Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) minutes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 5-15 60				20g. (County) 5-16 60			
21. I certify that (I) (the hospital) attended the deceased from 5-15 60 to 5-16 60 , that (we) last saw the deceased alive on 5-16 60 , and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE D. J. Boyer				22b. DATE SIGNED 5-17-60			
22c. PHYSICIAN'S NAME (Type) Drs. D.J. Boyer & J.D. Wilson				22d. ADDRESS 135 North Potomac Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/19/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town, or county) Hagerstown				23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Suter Rouzer Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MASSACHUSETTS DEPARTMENT OF HEALTH
BIRTH CERTIFICATE OF DEATH

6816

(M)

NAME OF DECEASED	WILLIAM ALMON	AGE	1 year
DATE OF BIRTH	10-11-1911	PLACE OF BIRTH	WILMINGTON, MASS.
DATE OF DEATH	10-11-1911	PLACE OF DEATH	WILMINGTON, MASS.
CAUSE OF DEATH	DIPHTHERIA		
DATE OF EXAMINATION	10-11-1911	PLACE OF EXAMINATION	WILMINGTON, MASS.
NAME OF PHYSICIAN	DR. J. B. ALLEN		
NAME OF BURIAL PLACE	WILMINGTON CEMETERY		
NAME OF MINISTER	REV. J. B. ALLEN		
NAME OF WITNESSES	J. B. ALLEN, M.D. J. B. ALLEN, M.D.		

[Faint, illegible text and signatures at the bottom of the page, likely representing the registrar and witnesses.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6360

CERTIFICATE OF DEATH

06297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghmanton Md.		c. LENGTH OF STAY IN 1b 90 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Tilghmanton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Albert Last Moats		4. DATE OF DEATH Month May Day 14 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7 1869
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR Months 8 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Md. State Roads	
11. BIRTHPLACE (State or foreign country) Tilghmanton Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jacob Moats		14. MOTHER'S MAIDEN NAME Anna Mongan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louise Rickard		Address Tilghmanton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) 5 Yr Plus		INTERVAL BETWEEN ONSET AND DEATH 30 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481x Influenza		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from on 5/1/14/60. to 19 that I last saw the deceased alive on April 22 19 60 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED Walter H. Shealy			
ACTUAL SIGNATURE Walter H. Shealy M.D.		PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18-60	
22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		22d. LOCATION (City, town, or county) (State) Near Tilghmanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf		ADDRESS Williamsport, Md	
24a. REC'D BY REGISTRAR DATE MAY 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

6230

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6421

CERTIFICATE OF DEATH

06381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Traskin</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 26 RFD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZA WATERS</u>		4. DATE OF DEATH Month Day Year <u>5 22 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEYIN CONWAY</u>		14. MOTHER'S MAIDEN NAME <u>MARIA GATTIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Rada Conway, Traskin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Uterus</u> DUE TO <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Hemiplegia Terminal Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 April 1950</u> to <u>22 May 1960</u> , that I last saw the deceased alive on <u>22 May 1960</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H Saunders</u> M.D.		DATE SIGNED <u>5/23/60</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H SAUNDERS</u>		<u>NANTICOKE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grace's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Traskin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty</u>		ADDRESS <u>Easton, Md.</u>	
24a. REG. BY REGISTRAR DATE <u>JUN 1 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

STATE DEPARTMENT OF HEALTH—BALTIMORE 15

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6317

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06298

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>2 HOURS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THURSTON</u> Middle <u>B</u> Last <u>MULLENDORE</u>				4. DATE OF DEATH Month <u>MAY</u> - Day <u>4</u> - Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 17 - 1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT AND FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS AND FARM</u>		11. BIRTHPLACE (State or foreign country) <u>CAPLAND WASH. Co. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>DAVID D. MULLENDORE</u>			
14. MOTHER'S MAIDEN NAME <u>SUSAN JENNINGS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>420.00</u>				17. INFORMANT Address <u>MRS. NAOMI MULLENDORE Boonsboro MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.00</u> DUE TO (c) <u>420.00</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-13-1959</u> to <u>5-4-1960</u> that (I) (we) last saw the deceased alive on <u>5-4-1960</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>				22b. DATE <u>5-5-1960</u> SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>				22d. ADDRESS <u>21 N. Main St., Boonsboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 6 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. West</u>				25. ADDRESS <u>BOONSBORO MD.</u>		26. REC'D BY REGISTRAR DATE <u>MAY 9 60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6318

CERTIFICATE OF DEATH

06299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Bedford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Everett 75-X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) 181 Belview Ave.				d. STREET ADDRESS Star Route		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle Roy Last O'Neal				4. DATE OF DEATH Month May Day 29 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Bedford Co., Penna.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John O'Neal				14. MOTHER'S MAIDEN NAME Alice Dicken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. 162-12-4139			
17. INFORMANT Frederick R. O'Neal, Hagerstown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis, Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hours years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 29 May 1960				20g. (County) 29 May 1960		20h. (State) 10:00 AM	
21. I certify that I attended the deceased from 29 May 1960 to 29 May 1960 , that I last saw the deceased alive on 29 May 1960 , and that death occurred at 10:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John D. Wilson				DATE SIGNED 131 N Potomac St Hagerstown, Md 5/30/60			
PHYSICIAN'S NAME (Type) John D. Wilson				ADDRESS 135 N. Potomac St., Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1960		22c. NAME OF CEMETERY OR CREMATORY Chaneyville Cemetery		22d. LOCATION (City, town, or county) (State) Chaneyville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS DATE MAY 31 '60		24a. REC'D BY REGISTRAR Arthur L. Hume	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1912

Age

Sex

Marital Status

Occupation

Place of Birth

Place of Death

Place of Burial

Place of Interment

Date

Time

Hour

Minute

Year

Month

Day

Hour

Minute

Place of Birth

Place of Death

Place of Burial

Place of Interment

Year

Place of Birth

Place of Death

Place of Burial

Place of Interment

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Berkeley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Williamsport Pike	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle William Last Painter		4. DATE OF DEATH Month May Day 26 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 1 Days 17	IF UNDER 24 HRS. Hours 1 Min. 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Plant Loudon Co. Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Painter		14. MOTHER'S MAIDEN NAME Annie Hardy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. J.W.Painter		Address Martinsburg W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.) 1. Coronary atherosclerosis, severe. DUE TO (b) 2. Coronary occlusion, old Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 3. Cardiac hypertrophy DUE TO (c) 4. Ischemic fibrosis of myocardium			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) E. W. Ditto, Jr., M.D.		DATE SIGNED 5/26/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/60	
22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		ADDRESS Martinsburg W.Va.	
24a. REC'D BY REGISTRAR DATE MAY 31 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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WILLIAMSON, J. 1990. *Journal of Fish Biology* 37: 1-10.

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Yoshida, K. 1983. *Journal of the Japanese Botanical Society* 58: 1-10.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert. et

CERTIFICATE OF DEATH

6320

06302

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 10 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PETERSON,		4. DATE OF DEATH Month May Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1960
9. AGE (In years lost birthday) yrs. 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Douglas Haig Morgan Peterson		14. MOTHER'S MAIDEN NAME Wanda Yvonne Himes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Twin #2 delivered by section		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11, 1960 , 19____, to May 11, 1960 19____, that I last saw the deceased alive on May 11, 1960 19____, and that death occurred at 12:41 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St., Hagerstown, Md. DATE SIGNED			
ACTUAL SIGNATURE F. D. Dove Jr. M.D.			
PHYSICIAN'S NAME (Type) F. D. Dove, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/12/60	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hospital Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. D. Dove Jr.		24a. REC'D BY REGISTRAR DATE MAY 20 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2281301XV0

CERTIFICATE OF DEATH

1320

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. AGE [Age of deceased]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. MARITAL STATUS [Married/Single/etc.]</p>		<p>8. CAUSE OF DEATH [Cause of death]</p>	
<p>9. MEDICAL HISTORY [Medical history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>11. SIGNATURE OF REGISTRAR [Signature]</p>		<p>12. DATE OF DEATH [Date of death]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert. et

6321

CERTIFICATE OF DEATH

06301

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 10 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 23 Wynnwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PETERSON, First Middle Last				4. DATE OF DEATH May 11, 1960 Month Day Year 19			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1960	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME DOUGLAS HAIG MORGAN PETERSON				14. MOTHER'S MAIDEN NAME WANDA YVONNE HIMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEDICAL RECORD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Cerebral DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Twin #1 DELIVERED BY SECTION							
INTERVAL BETWEEN ONSET AND DEATH 10 min.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 11, 1960 , to May 11, 1960 , that I last saw the deceased alive on May 11, 1960 , and that death occurred at 12:41 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5/11/60 ACTUAL SIGNATURE F. D. Dove Jr. M.D. PHYSICIAN'S NAME (Type) F. D. DOVE, JR., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 5/12/60		22c. NAME OF CEMETERY OR CREMATORY WASH. CO. HOSPITAL LAB.		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. D. Dove Jr.				ADDRESS 214 N. Potomac St. Hag. Md.		24a. REC'D BY REGISTRAR DATE MAY 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

Nov 6/60

2181301XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

6322

CERTIFICATE OF DEATH

06303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>25 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>1310 OAK HILL AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>DeWEESE</u> Last <u>PLUMMER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>19 60</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/1893</u>
9. AGE (In years lost birth day) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROAD CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ROAD BLDG.</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS W. PLUMMER</u>		14. MOTHER'S MAIDEN NAME <u>MARY R. DeWEESE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or date) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-8791</u>	
17. INFORMANT <u>MRS. JESSE PLUMMER</u>		Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4 20.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>1-2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 May, 1960</u> to <u>31 May, 1960</u> , that I last saw the deceased alive on <u>31 May, 1960</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.		ADDRESS (Street, city or town, state) <u>1135 POTOMAC AVENUE</u> DATE SIGNED <u>1 JUNE 1960</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>		<u>HAGERSTOWN</u> <u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hornum</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

332

CERTIFICATE OF DEATH

STATE OF NEW YORK

1900



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 445 N. Mulberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle MAIN Last ROLLS				4. DATE OF DEATH Month May Day 15 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Electronic Mfg.		11. BIRTHPLACE (State or foreign country) Front Royal, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank M. Ralls				14. MOTHER'S MAIDEN NAME Gertrude Clatterbuck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-1929		17. INFORMANT Address Mr. Wilbur Ralls 116 Elm St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2nd. & 3rd. Degree Burns Involving 60% of Entire Body. DUE TO (c) Body.						INTERVAL BETWEEN ONSET AND DEATH 11 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cleaning fluid he was using suddenly ignited.					
20c. TIME OF INJURY Month, Day, Year Hour 5/16/1960 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory		20f. (City or town) (County) (State) Hagerstown, Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Wm. A. Horst		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35 years		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Room 306, Federal Bureau of Investigation Building, Washington, D.C.	
7. TIME OF DEATH 11:00 AM		8. CAUSE OF DEATH Suicide by gunshot wound of the chest	
9. MANNER OF DEATH Suicide		10. SIGNATURE OF EXAMINER [Signature]	
11. SIGNATURE OF DECEASED [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. SIGNATURE OF MEDICAL EXAMINER [Signature]		14. SIGNATURE OF CORONER [Signature]	
15. SIGNATURE OF POLICE OFFICER [Signature]		16. SIGNATURE OF JURY [Signature]	
17. SIGNATURE OF DISTRICT ATTORNEY [Signature]		18. SIGNATURE OF CLERK [Signature]	
19. SIGNATURE OF CHIEF OF POLICE [Signature]		20. SIGNATURE OF SHERIFF [Signature]	
21. SIGNATURE OF JUDGE [Signature]		22. SIGNATURE OF PROSECUTOR [Signature]	
23. SIGNATURE OF DEFENSE COUNSEL [Signature]		24. SIGNATURE OF JURY [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]	
27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF WITNESS [Signature]	
29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]	
33. SIGNATURE OF WITNESS [Signature]		34. SIGNATURE OF WITNESS [Signature]	
35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
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39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF WITNESS [Signature]	
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45. SIGNATURE OF WITNESS [Signature]		46. SIGNATURE OF WITNESS [Signature]	
47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]	
51. SIGNATURE OF WITNESS [Signature]		52. SIGNATURE OF WITNESS [Signature]	
53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]	
55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]	
57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF WITNESS [Signature]	
59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]	
63. SIGNATURE OF WITNESS [Signature]		64. SIGNATURE OF WITNESS [Signature]	
65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]	
67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]	
69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF WITNESS [Signature]	
71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]	
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83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]	
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91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]	
95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]	
99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6324 CERTIFICATE OF DEATH 302 06305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 1/2 Hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 101 So Potomac St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE MAY REEDER-HAMBURG				4. DATE OF DEATH Month Day Year May 22 1960 19			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5 1882 9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during max of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Mohroe Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Longaneoker				14. MOTHER'S MAIDEN NAME Martha Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-12-0104		17. INFORMANT Address Theodore G. Reeder 1107 Orchard Hill Pkwy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute pulmonary Edema DUE TO (b) hypertensive Cardio-Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 22, 1960 to May 22, 1960 , that (I) (we) last saw the deceased alive on May 22, 1960 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE John D. Turco				22b. DATE SIGNED 5-23-60		22c. PHYSICIAN'S NAME (Type) JOHN D. TURCO	
22d. ADDRESS 302 N. POTOMAC ST HAGERSTOWN, MD				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE MAY 26 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

ON 30

CERTIFICATE OF DEATH

324

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



081

1

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6325

Item / 6-6-60 et

CERTIFICATE OF DEATH

06306

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE HALL - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hospital</u>				/ d. STREET ADDRESS <u>HAGERSTOWN MD. R.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARMENIA A. REESE</u>				4. DATE OF DEATH Month Day Year <u>MAY - 27 - 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 11 - 1868</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>6 16</u>		IF UNDER 24 HRS. <u>6 16</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WESLEY CASTLE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH POWLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. RALPH STOTLER HAGERSTOWN MD. R.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 Yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> <u>1957</u> to <u>5/27</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> <u>1960</u> , and that death occurred at <u>3:40</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>5/27/60</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>				22d. ADDRESS <u>Smithsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 29 - 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Barlow</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	

60300

CERTIFICATE OF DEATH

1335



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6326

CERTIFICATE OF DEATH

Reg. Dist. No.

06307

1. PLACE OF DEATH o. COUNTY WASHINGTON MIDDLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 225 WINTER ST.		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISY Middle ELLEN Last REICHARD		4. DATE OF DEATH Month MAY Day 12 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years lost birthday) 88 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. FOX		14. MOTHER'S MAIDEN NAME CORNELIA BUHRMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS BESSIE EYLER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO arteriosclerotic C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH see yr yes			19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/11/60 , 19____, to 5/12/60 , 19____, that I last saw the deceased alive on 5/11/60 , 19____, and that death occurred at 2:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Howard N. Weeks M.D. 136 N. Potomac St. 5/13/60 PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/14/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR MAY 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1910

CERTIFICATE OF DEATH

0350

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

0350

W. J. McManus, Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06308

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last RIFE				4. DATE OF DEATH Month May Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1869		9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Freight Conductor				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Norwich, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Elmer Rife Address Ridgefield, New Jersey			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver. 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 19, 1969 to May 19, 1960 , that (I) (we) last saw the deceased alive on May 18, 1960 , and that death occurred at 2P M, from the causes and on the date stated above.							
22a. SIGNATURE <i>R.A. Bell</i>				22b. DATE SIGNED 5-20-60		22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.	
22d. ADDRESS 19 North Potomac Street Hagerstown, Maryland.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/1960		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Elmira New York	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Spier - Rouzer Funeral Home</i>				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 23 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1030

MINISTRY OF HEALTH
CERTIFICATE OF DEATH

(M)

Washington

Washington

Washington

22 years

22 years

Washington

Washington

Female

Female

Female

1915

September 1, 1915

Washington

Washington

Washington

Washington

No

No

No

Washington

Washington

1030

1030

1030

1030

1030

1030

1030

1030

CERTIFICATE OF DEATH

Reg. Dist. No.

6328

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GROSS Middle GROVE Last RODERICK		4. DATE OF DEATH Month May Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1896
9. AGE (In years lost birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar Roderick		14. MOTHER'S MAIDEN NAME Emma Grove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-7525	
17. INFORMANT Mrs. E.G. Roderick R#1		Address Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. arteriosclerosis (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 4, 1960 to May 24, 1960 , that I lost saw the deceased alive on May 24, 1960 , and that death occurred at 8:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 136 North Potomac St. 5/25/60 ACTUAL SIGNATURE Howard N. Weeks, M.D. PHYSICIAN'S NAME (Type) Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 28, 1960	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE MAY 31 1960
		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1932

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1932

Full Name

Address

City

State

County

Age

Sex

Marital Status

Occupation

Education

Religion

Color

Birth Date

Birth Place

Death Date

Death Place

Cause of Death

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)
15M 9/59

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6346

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06310

1. PLACE OF DEATH a. COUNTY <i>Washington</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i> c. LENGTH OF STAY IN 1b <i>3 weeks</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>				d. STREET ADDRESS <i>Route #3</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles</i>		First <i>Henry</i>		Middle <i>Schamel</i>		Last	
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <i>May</i> Day <i>12</i> Year <i>1960</i>	
9. AGE (In years, lost birthday) <i>75</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>George C. Schamel</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cushen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-30-9672</i>		17. INFORMANT <i>Winfield M Schamel</i>		Address <i>Rural 3 Hagerstown Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ac - myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/11/60</i> to <i>5/12/60</i> , that (I) (we) last saw the deceased alive on <i>5/11/60</i> , and that death occurred on <i>5/12/60</i> at <i>2:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Ralph Young</i>				22b. DATE SIGNED <i>5/12/60</i>		22c. PHYSICIAN'S NAME (Type) <i>Ralph Young</i>	
22d. ADDRESS <i>Williamsport Md.</i>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5.15.60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Lawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Williamsport Washington Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Howard J. Glover Hancock</i>				25a. REC'D BY REGISTRAR <i>MAY 18 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimes</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6329

CERTIFICATE OF DEATH

06311

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 17 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle MASTERS Last SCHNEBLY		4. DATE OF DEATH Month MAY Day 12 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 16, 1860
9. AGE (In years lost birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY MAIL CARRIER	
11. BIRTHPLACE (State or foreign country) WASHINGTON CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB SCHNEBLY		14. MOTHER'S MAIDEN NAME FRANCES MARION ROWLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT MRS GUY ANGLE		Address BIG SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, TERMINAL BILATERAL 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDITIS, CHRONIC DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE, HIP RIGHT APRIL 24, 1960		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FELL AT HOME APRIL 24, 1960		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME APRIL 24, 1960	
20c. TIME OF INJURY Month, Day, Year Hour o. m. APR 24 19 60 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) CHAIRMAN, PENNSYLVANIA	
21. I certify that (I) (this hospital) attended the deceased from APRIL 25 19 60 , to MAY 12 19 60 , that (I) (we) last saw the deceased alive on MAY 12 19 60 , and that death occurred at 4:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED MAY 14, 1960	
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		22d. ADDRESS CLEAR SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 14, 1960	
23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>		25a. REC'D BY REGISTRAR MAY 16 '60	
ADDRESS CLEAR SPRING, MD.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

6359

DATE OF DEATH

OR DAYS

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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EDUCATION

DATE OF BIRTH

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PNEUMONIA, TERMINAL BILATERAL

MYOCARDITIS, CHRONIC

ARTERIOSCLEROTIC HEART DISEASE

FRACTURE, HIP RIGHT, APRIL 24, 1960

FELL AT HOME APRIL 24, 1960

X HOME

APR 24 1960

MAY 12 1960

APRIL 23 1960

MAY 12 1960

CLERK, BUREAU, MAY 12 1960

ARCHIVED, MAY 12 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6330

CERTIFICATE OF DEATH

06312

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1535.2	
f. STREET ADDRESS 10009 Greenock Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Clarke Last Seavers		4. DATE OF DEATH Month May Day 31 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/1900
9. AGE (In years, lost birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Overton Clarke		14. MOTHER'S MAIDEN NAME Mary Ellen Stokes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Edward Stafford		Address Wash, D.C. 3818 Garrison St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fibrinous pericarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Empyema, left DUE TO (c) Lobular pneumonia, bilateral		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) subacute & chronic pyelonephritis (2) Diabetes mellitus (3) Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1959 to May 31, 1960 , that (I) (we) last saw the deceased alive on May 31, 1960 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos		22b. DATE SIGNED May 31, 1960	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS		22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF June 2, 1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,		25a. REC'D BY REGISTRAR JUN 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Donald Seibel, Jr.</u>				4. DATE OF DEATH Month Day Year <u>5 19 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/56</u>	9. AGE (In years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Oakland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James Donald Seibel</u>			14. MOTHER'S MAIDEN NAME <u>Delores Allen</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u>		Address <u>— Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic leukemia, acute</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>				
21. I certify that I attended the deceased from <u>2/13</u> , 19 <u>60</u> , to <u>5/19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>60</u> , and that death occurred at <u>9:00 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Young</u>		M.D. <u>101 King Street</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>5/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5.23.60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peters Catholic</u>	22d. LOCATION (City, town, or county) <u>Brownsville, Fayette</u> (State) <u>Penna.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>		ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06314

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN RURAL</u>				c. LENGTH OF STAY IN 1b <u>10 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DAY ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RUSSELL JOSEPH SHANK</u>				4. DATE OF DEATH <u>MAY 23 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 9 - 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR <u>6</u> Months <u>14</u> Days		IF UNDER 24 HRS. <u>6</u> Hours <u>14</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE OF WASH. CO. SCHOOL BOARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CLEARSPRING WASH. CO. MD U.S.A</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JOHN B. SHANK</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA MYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-16-3379</u>			
17. INFORMANT <u>MRS. MYREE SHANK</u>				Address <u>DAY ROAD, HAGERSTOWN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> 420.0 DUE TO (b) <u>INTERVAL BETWEEN ONSET AND DEATH June 14 - 1957</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 5 1960</u> to <u>May 23 1960</u> , that (I) (we) last saw the deceased alive on <u>May 23 1960</u> , and that death occurred at <u>12 M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidney Novenstein</u>				22b. DATE SIGNED <u>5-24-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>				22d. ADDRESS <u>2 North town md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 26 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>NEAR CLEARSPRING MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				25a. REC'D BY REGISTRAR <u>MAY 26 60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 6332 CERTIFICATE OF DEATH 06315									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Downsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital					d. STREET ADDRESS Downsville Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sallie Middle Elizabeth Last Shank					4. DATE OF DEATH Month May Day 25 Year 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23 1877		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Downsville Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Andrew Bowers					14. MOTHER'S MAIDEN NAME Maggie Lynch				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Roy Shank Williamsport Md RFD #1					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrest 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 5 min 540	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular accident								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-19 19 59 to 8-24 19 60 that (I) (we) lost saw the deceased alive on 5-24 19 60 , and that death occurred 11:26 AM , from the causes and on the date stated above.									
22a. SIGNATURE Max E. Byrkit					a. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS 28 W. Potomac St Williamsport, Md				
22c. PHYSICIAN'S NAME (Type) Max E. Byrkit, M.D.					22d. ADDRESS 28 W. Potomac St Williamsport, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 28-60		23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery			23d. LOCATION (City, town, or county) (State) Bakersville Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport Md					25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines		



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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06316

6362

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upton</u> <u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hawn Nursing Home</u>		d. STREET ADDRESS <u>Upton, Penna.</u>	
3. NAME OF DECEASED (Type or print) <u>Maggie</u> First <u>C.</u> Middle <u>Shindle</u> Last		4. DATE OF DEATH <u>May</u> Month <u>4</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Schaff</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gearhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NI</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>James Shindle - Waynesboro, Pa.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiac Insufficiency</u> DUE TO <u>15 years</u> (c) <u>Dilated Myocardium</u> <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> 19 <u>59</u> , to <u>May 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>60</u> , and that death occurred at <u>6:55 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Kiefer</u> M.D. <u>Blue Ridge Summit, Pa.</u>		DATE SIGNED <u>5 May 60</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Kiefer, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>5/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnick - Greencastle Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 9 60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Minnick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

6333

See: Birth Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No.

06317

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>E. Water Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Smith</u>		4. DATE OF DEATH Month Day Year <u>May 14 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Fishack Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Patricia Switzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>F. D. Dove Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. F. D. Dove, Jr.</u>		<u>214 N. Potomac St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hospital Lab.</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. D. Dove Jr.</u> ADDRESS <u>Hagerstown</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 325 Robinwood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christine Marie Smith		4. DATE OF DEATH May 14 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1951
9. AGE (In years last birthday) 8 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl	11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Lindsay Smith	
14. MOTHER'S MAIDEN NAME Anna Jean Morgan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. James L. Smith Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Fracture Of Right Tibia & Fibia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Of Left Humerus DUE TO (c) Fracture Of Skull		INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by a car while crossing road.	
20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 5/14/1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Hagerstown, Wash. (County) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DATE SIGNED 5/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/1960	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06319**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg			c. LENGTH OF STAY IN 1b 2 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 108 Church Street				d. STREET ADDRESS 108 Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mark Middle Anthony Last Smith				4. DATE OF DEATH Month May Day 14 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30 1957		
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 5 Days 12		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Willie Frances Smith				14. MOTHER'S MAIDEN NAME Hazel Marguerite Bussard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Willie Smith 108 Church Street Sharpsburg Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) 929.0 (c) Instant								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Child fell in run in rear of home								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child fell in run in rear of home						
20c. TIME OF INJURY Month, Day, Year Hour 2:30 a.m. 5-14-60 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Sharpsburg Washington Md		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE S. E. Smith				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) H. F. W. J. I. T. O. 2				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17-60		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf ADDRESS Williamport, Md				24a. REC'D BY REGISTRAR DATE MAY 17 '60		24b. REGISTRAR'S SIGNATURE Charles E. K...		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a copy is necessary, please enclose a copy of this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>2 weeks 5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>M.</u> Last <u>Stahl</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Williamson, Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Conrad Hartmann</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Long</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary R. Stahl, 230 N. Potomac St., Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Carcinomatosis</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Squamous cell Ca</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Small abscess</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 24, 1960</u> to <u>May 29, 1960</u> that I last saw the deceased alive on <u>May 29, 1960</u> , and that death occurred at <u>9:59</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Byrkit</u>		ADDRESS (Street, city or town, state) <u>28 W. Potomac</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		DATE SIGNED <u>Williamsport Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MERCERSBURG, PA.</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>W. E. Byrkit</u>		24a. REC'D BY REGISTRAR <u>MUN 6 '60</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Byrkit</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6335

CERTIFICATE OF DEATH

06321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wagons town</u>				c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOUIS</u> First <u>A.</u> Middle <u>STRITE</u> Last				4. DATE OF DEATH <u>May 25</u> Month <u>May</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/1901</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Strite</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie B. Landis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Floyd A. Strite - Smithsburg, Md.</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u> <u>5 Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>—</u> Year <u>—</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-8</u> , 19 <u>55</u> , to <u>5-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>60</u> , and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D.				ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>5-26-60</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>5/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stouffers Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6336
CERTIFICATE OF DEATH
06322

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 21Mons d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 549 Frederick, Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03 d. STREET ADDRESS 140 North Locust, Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AUDA MAE SWAIN				4. DATE OF DEATH May 19 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1900 59	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Top Stitcher		11. BIRTHPLACE (State or foreign country) Davis Tucker Co, W.Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Franklin Larrick				14. MOTHER'S MAIDEN NAME Fannie C. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2169		17. INFORMANT Mrs. Edna Cromer, 549 Frederick St Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, kidney failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Pyelonephritis and abscess rt. kidney DUE TO (c) Calculus right renal pelvis						INTERVAL BETWEEN ONSET AND DEATH days weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1958 , to May 19, 1960 , that (I) (we) last saw the deceased alive on May 12, 1960 , and that death occurred at 11P M, from the causes and on the date stated above.							
22a. SIGNATURE John C. Stauffer, M.D.				22b. DATE SIGNED MAY 23 '60		22c. ADDRESS Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/60		23c. NAME OF CEMETERY OR CREMATORY Timber Ridge Cemetery		23d. LOCATION (City, town, or county) (State) High View Hampshire Co W.Va	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md				25a. REC'D BY REGISTRAR DATE MAY 23 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

633 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>65 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>821 Virginia Ave.</u>											
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1960</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Quarry</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>William Taylor</u>						14. MOTHER'S MAIDEN NAME <u>Matilda Wolfe</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213 09 9625</u>		17. INFORMANT <u>Mrs. Maud Taylor</u> <u>821 Virginia Ave. Hagerstown Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Contusion & Laceration</u> DUE TO (c) <u>Comminuted Fracture Of Pelvis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>4</u> hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by automobile while crossing street.</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>9:40</u> a. m. <u>5-29-1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>				20f. (City or town) <u>Hagerstown, Wash. Md.</u>		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>[Signature]</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>5-31-60</u>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>				22d. LOCATION (City, town, or county) <u>Williamsport Md.</u>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Deaf Williamsport, Md</u>						ADDRESS <u>Williamsport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6338

CERTIFICATE OF DEATH

06324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Convalescent Hospital				e. STREET ADDRESS 425 Guilford Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle Hawkins Last Wills				4. DATE OF DEATH Month May Day 10 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1885		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) kitchen assistant		10b. KIND OF BUSINESS OR INDUSTRY resturant		11. BIRTHPLACE (State or foreign country) Toms Brook, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Hawkins				14. MOTHER'S MAIDEN NAME Effie Lutholtz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-14-6756A		INFORMANT Address Harold E. Wills, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 19 60 to May 10, 19 60 , that I lost sow the deceased alive on May 9, 19 60 , and that death occurred at 5:45 A M, from the causes ond on the date stated above.							
ACTUAL SIGNATURE B. B. Kneisley		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 148 West Washington St. 5/11/60					
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-12-60		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Strawsburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS MAY 12 '60		24a. REC'D BY REGISTRAR Arthur S. Kraus	

6364

CERTIFICATE OF DEATH

06325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, R.D.</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood, Evan, Refd. Home</u>				d. STREET ADDRESS <u>10X-2</u>			
3. NAME OF DECEASED (Type or print) <u>EFFIE V. WINGER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>II.</u> Year <u>1960</u> 19			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15. 1870</u>	9. AGE (In years last birthday) yrs. <u>89</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own. Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>John G. Winger</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Bowman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				INFORMANT <u>Homewood Records</u> Address <u>Williamsport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>hrs.</u> <u>hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>May 12</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>May 8</u> , 19 <u>60</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis G. Gratt</u>		M.D. <u>119 E. Antietam</u>		ADDRESS (Street, city or town, state) <u>5/13/60</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Louis G. Gratt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May, II, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>	22d. LOCATION (City, town, or county) <u>Mercersburg Franklin Co Pa.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Croager</u>		ADDRESS <u>Thurmont.</u>		24a. REC'D BY REGISTRAR <u>MAY 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6384

Washington

Interposed.

County of

State of

July

Home

Home

Home

Witnessed by me,
Notary Public for the District of Columbia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6339

CERTIFICATE OF DEATH

06326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg</u>		c. LENGTH OF STAY IN 1b <u>6 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesburg Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash Co Hosp.</u>				d. STREET ADDRESS <u>1195 Mechanic Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Keith</u> Last <u>Zimmerman</u>				4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/59</u>		9. AGE (In years last birthday) yrs. <u>9</u> IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Leesburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John T. Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Audrey Jeannine Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> DUE TO <u>Gastroenteritis + Acetosis severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Virus infection</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>2 days</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> o. p. <u>—</u> p. m. <u>—</u> 19 <u>60</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
				20f. (City or town) <u>—</u>		(County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>4/30</u> , 19 <u>60</u> , to <u>5/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/1</u> , 19 <u>60</u> , and that death occurred at <u>1:57</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Young</u>				M.D. <u>—</u>		ADDRESS (Street, city or town, state) <u>101 King Street</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>				DATE SIGNED <u>5/1/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Samplers Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Samplers Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Donald Cables</u>				ADDRESS <u>Harpers Ferry West Va.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cirilo J. H.</u>			

11

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John J. Zimmerman

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

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Reg. Dist. No.

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|--|---------------------------|--|--------------------------------------|--|-----------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocky Ridge</u> <u>10X-2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u> | | | | d. STREET ADDRESS <u>Rocky Ridge</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM KOONS ZIMMERMAN</u> | | | | 4. DATE OF DEATH <u>May 15 1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 8, 1876</u> | 9. AGE (In years lost birthday) <u>83</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shaper + Bohmer, Inc. Mfg. Chemists.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Michael J. Zimmerman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura C. Koons</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>164-05-0052</u> | | | |
| 17. INFORMANT <u>Mr. Wm. G. Kolb, Rocky Ridge, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
DUE TO <u>transitional cell</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of Bladder</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>
<u>1 yr.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. ft. p. m. _____ Month, _____ Day, _____ Year <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>6:30 AM</u> , 19 <u>60</u> , to <u>7:00 AM</u> 19 <u>60</u> , that I last saw the deceased alive on <u>15 May</u> , 19 <u>60</u> , and that death occurred at <u>7:00 A.</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>Harold H. Gist</u> M.D. _____
PHYSICIAN'S NAME (Type) <u>Dr. Harold H. Gist</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/18/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Creegerstown</u> | | 22d. LOCATION (City, town, or county) (State) <u>Creegerstown Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>S. C. Barton</u> ADDRESS <u>Walkersville, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

